

**South Carolina Department of Disabilities and Special Needs
Consumer Assessment Team
Request for ICF/MR Level of Care for the PDD Waiver**

Date: _____

Consumer: _____

Consumer's Address: _____

County of Residence: _____

Medicaid #: _____

SSN#: _____

Board/Provider: _____

Dist. Office Rep/QMRP: _____
(for ICF/MR consumers)
SC/EI and phone #: _____

SC/EI E-mail address: _____

LOC Request	Eligibility Category
<input type="checkbox"/> Initial LOC (First time sent to CAT)	<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> Initial LOC (Consumer disenrolled/seeking to re-enter the PDD Waiver)	<input type="checkbox"/> Related Disability _____ Specify
<input type="checkbox"/> Initial LOC (expired) <div style="margin-left: 20px;"><input type="checkbox"/> Enrollment did not occur within 30 days of LOC effective date OR <input type="checkbox"/> Over 365 days old Copy of last LOC dated _____ (Included with packet)</div>	<input type="checkbox"/> High Risk Infant/At Risk Child
<input type="checkbox"/> Annual Re-evaluation for time Copy of last LOC date: _____ (Included with Packet)	<input type="checkbox"/> Spinal Cord Injury
	<input type="checkbox"/> Head Injury <input type="checkbox"/> Similar Disability _____ Specify

TO BE COMPLETED BY CAT LOCATED AT THE MIDLANDS FIELD OFFICE

Level of Care Effective Date: _____ ☐ **Found to not meet ICF/MR Level of Care**

SC, EI, QMRP, or District Office Rep

Service Coordinator/Early Intervention Supervisor

SAMPLE